ACCESS TO 'SAFE AND LEGAL ABORTION' ISSUES AND CONCERNS

SUMMARY REPORT of THE STATE LEVEL CONSULTATION

Held on June 7, '98, Pune

Cehat

Research Centre of Anusandhan Trust

September 1998

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Under the project

A RESEARCH AND ADVOCACY PROGRAMME FOR IMPROVING QUALITY OF ABORTION CARE (REAP)

Cehat

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Content

(I) Introduction

The Medical Termination of Pregnancy (MTP) Act has been in force since last 25 years. However, the providers of MTP care and women who seek MTP services still face problems affecting women's access to abortion care. Our team in CEHAT has been engaged for the last three years in research to understand the obstacles in access to 'safe and legal abortion'. We have had intense interactions with women as well as providers of abortion services in the course of our study. Our findings have led us to draft certain recommendations for improving the access to safe and legal abortions. There are certain issues which, we felt, need to be thoroughly debated before being integrated in the recommendations. It is high time we review the effectivity of the Act and propose necessary changes.

This Consultation was organised basically to discuss the issues arising out of the study with the aim of moving towards sound and feasible recommendations. We needed considered opinions of representatives of concerned constituencies such as medical professionals from different systems of medicines, paramedics, health activists and health researchers on these issues for evolving the advocacy campaign. This Consultation was the first in the series that we plan to organise in this year to build a lobby of various concerned constituencies to improve women's access to safe and legal abortion.

This consultation has been a step towards establishing a platform for an ongoing discussion on the issue and campaigning for necessary changes. Active participation of the representatives of the concerned constituencies in this consultation has made headway in the direction that we all wanted.

From the organiser's side the research team who is working on the issue prepared one research paper based on the empirical data and three discussion papers (pl find the abstracts enclosed). The research paper titled 'Access to Abortion Care ...' highlighted the appalling status of abortion care services with the help of the micro level empirical data. Physical, socio-cultural, financial, political and legal dimensions of access to abortion care were the thrust areas. The discussion papers were mainly to evaluate the

feasibility of menstrual regulation as an abortion method, non-allopaths in the MTP services, and paramedics in MR services.

In addition, in each of three sessions there were contributions from the participants. This made it possible to provide a platform for various concerned constituencies to express their viewpoints on issues related to safe & legal abortion facilities and to facilitate meaningful post-presentation discussions.

We are glad to bring out this summary report of the consultation highlighting the issues and concerns related to access to safe and legal abortion care that were deliberated upon and recommendations evolved through the discussion for improving the prevailing status of abortion care.

(II) Presentations, Discussions and Recommendations

(A) Session I
Access to abortion care services

Highlights of the presentation

In this session there were two presentations from the organiser and one from amongst the participants. The presenters from CEHAT began with a short review of the abortion research that is in progress in CEHAT for the past three and a half years. The presenters elicited from their survey data the prevailing disparities in abortion care between rural and urban areas; the inadequacies of the public health care sector; the preponderance of non-registered MTP centres in the private sector; and indulgence of non-qualifieds in the abortion care delivery. Erratic and unequal spatial distribution of the abortion care centres were also highlighted with the help of facts and figures. The inadequacies in the MTP Act in terms of restrictive access to abortion care, space for providers to interpret the Act only to work against women's interest; insistence of providers for husband's signature or consent for woman to go for an abortion which is a grossly erroneous and non-legal demand having negative implications for women's access to abortion care services were presented. Further, the providers' perceptions and views about the current situation of registration procedure and the process were also stressed upon. Thus, giving a comprehensive account of the prevailing situation of abortion care, the presenters emphasised the need to make efforts to address this multifaceted issue at hand.

Dr Deepti Chirmulay, BAIF, the presenter from the participants highlighted the problem areas in access to health care in general based on a multi-state study. She emphasised the significance of users' perceptions about quality of health care services. Public against private was the major analytical category used to draw inferences from the data. While education of the users influence their preferences for private or public, it was found that users from all classes do seek services from private health care sector. Non-availability of public health care centres and their poor quality have been the

major deterrents for poor women. People and users of health care services seek it from the private sector out of a 'no-choice' situation. The public health care sector has largely confined itself to preventive health measures and almost totally ignores people's need of curative care. When it comes to women, there is a colossal gap between their health care needs and the services in the public health care sector.

From the presentation it was brought out that though there are specific problems vis-à-vis abortion care services, it is equally important to take note of the problem areas in general health care services which impinge upon women's access to health care services.

Discussion

Various issues came up during the discussion regarding registration procedure for MTP service centre. The discussion focused around three issues. One, there are certain inherent problems in the MTP Act and its Rules and Regulations formulated by the State Government. Two, there are serious lacunae and problems at the implementation level. Three, there are problems arising out of misconceptions of abortion providers about the registration procedures and also about the registered status of abortion service centre. This is mostly because the providers are ill-informed about the registration requirements. It is rather difficult to attribute the low rate of MTP registration of medical care centres exclusively either to government authorities or to the providers. The issues are closely interlinked and impinge on each other.

1. Inherent problems in the Act related to registration procedure:

1.1 Paper work required for registration : Many of the doctor participants either were ill-informed about the formalities that are required to be completed or felt overwhelmed with the stipulated requirements. Procedural delay could be avoided if the concerned government authority provided a well explained form, eliminating ambiguities about the registration requirements.

Participants attributed this to lack of any locally available authority or enquiry window

for the providers to clear their doubts about the registration procedure. Even the registration forms are available only at the district level. This lacuna in the system seems to be affecting providers' access to information regarding registration procedure.

Recommendations :

- The registration form should be absolutely clear in its wording leaving 'no' ambiguity.
- Information should be disseminated at a local point easily approached by the providers or health care institutions as and when required.
- IEC component needs to be strengthened. The local public health care centres could be utilised as channels for registration information delivery system.

1.2 Decentralisation of the Power to Approve MTP centre : At present only the Directorate of Health Services (DHS), Mumbai has the authority to approve centres under the MTP legislation in Maharashtra as per the MTP registration procedure. The specified centres by the applicants are inspected by the Civil Surgeon (or his delegate) in the district hospitals. The application and the inspection reports are then forwarded to the DHS, Mumbai for approval. It was very strongly felt that the inspectors, that is, the Civil Surgeons and Medical Officers at district level be given the authority to inspect and approve a centre, instead of limiting this power exclusively to the DHS, Mumbai. Such an arrangement not only would enhance the convenience of the applicants and the inspecting authorities but would also help expedite the process of registration. Consequently it would also motivate medical professionals to go for registration.

Recommendation :

- Decentralisation of power from the State level to the district level to approve the centres as MTP service centres to go hand in hand with the prevailing decentralisation of authority/responsibility to physically inspect the health care centres of the applicants of MTP registration.

1.3 Minimum Physical Standards : The Act has stipulated certain minimum physical standards for a particular centre for providing MTP facilities. These include infrastructural facilities such as, operation theatre, operation table and anaesthetic

equipment in the centre. Besides these specifications in the Central Act, there are others laid down in the Rules and Regulations by the State Government about the assistant doctor and the assistant nurse involved in the MTP and the need for a blood bank in the vicinity of 5 km from the centre. In general, the concept of minimum physical standards was hailed and respected though not without differences of opinions on its details. Of course there were few medical professionals who were not in favour of having any of the minimum standards stipulated in the Act and felt that medical competence is most important and that should be the sole criterion for providing abortion care other than availability of facilities. However, majority did not agree with this as the minimum infrastructure that is stipulated in the MTP Act is to ensure the minimum physical standards for safe MTP procedures. In this regard one of the participants articulated the need for meeting minimum standards especially in remote areas to reduce abortion related morbidity and mortality.

The organising team shared views of abortion providers and/or the heads of institutions providing abortion services from Pune and Ratnagiri districts about the registration procedure. During this survey it was revealed that doctors are unwilling to go for registration if their centres are based in rental premises. According to them, shifting MTP care services to new premises require a fresh registration. This means in such situation s/he has to go through the registration procedure all over again. It is not surprising then that providers are reluctant to go through this procedure, which is complicated by the implementing authorities. Though this creates an obstacle, it appears to be a legally and for that matter logically justified stand on part of the implementors of the Act. This is because the physical standards that are stipulated in the MTP Act are specific to the particular set-up, such as, an operation table, anaesthetic equipment and are also location specific, viz. the distance of blood bank from the centre.

By and large it was expressed that blood bank requirement in the vicinity of 5 km around the centre as stipulated in the 'Rules and Regulations' of the Maharashtra State Government needs to be studied and reviewed from the point of view of necessity of blood transfusion during the second trimester abortions and practicality in the rural areas. The other related issues regarding the blood bank were, should this constitute the minimum physical standards for abortion service, per se; and how practical it is

to meet these requirements, especially against the backdrop of the government's policy regarding blood bank. It was told that the percentage of blood transfusion cases during abortion is about 0.1 per cent. The concern was expressed that in such situation how reasonable is it to include the 'blood blank in the vicinity of 5 km' as a prerequisite for an abortion centre to get the status of registered MTP centre.

The issue of Boyle's Apparatus for administering anaesthesia was also raised. It is an expensive equipment. Besides, the centres may have more sophisticated equipment that have come in the market. However the inspecting authorities insist on Boyle's apparatus. In this particular context it should be noted that the MTP Act does not detail anaesthetic equipment.

One of the participants while sharing his experiences during the registration procedure said that it is often very difficult to deal with these inspecting authorities about the specifications in the MTP Act. He said that the inspector insisted on the need to have iron spring cots which are extinguished species. This therefore, has been perceived as the harassment of the providers by the concerned authority.

In general the inspecting authority insists on such technology ignoring the advances in medical care. It appears that the inspecting authorities do not capture the spirit of the Act. Instead they get stuck at specific brands of the equipment (that too, according to their convenience). The Act, therefore, requires to undergo revisions at least on this level from time to time or else instead of specifying the names of the equipment it could only be the concept, viz. - anaesthetic equipment. It could be suggested in the body of the Act itself that the advances in the technology should be taken into account from time to time. And yet, it should be cautioned that all advanced technology need not be made compulsory.

Recommendations:

- Need to review the physical standards that are laid down in the Rules and Regulation of the Maharashtra State.
- The inspectors need to be trained so as to improve their understanding of the physical standards specifications in the MTP Act for better compliance.

1.4 Inadequacies in prevailing MTP Training facilities : Inadequate MTP training centres/facilities and poor content of training modules were the two major aspects that were discussed during the consultation.

Inadequate MTP training centres : Number of institutions that have been approved as MTP training centres are grossly inadequate. Since only government teaching hospitals provide such support, the infrastructure and the strength of the trainers at these centres often fall short of the actual needs. Both, the trainees and the trainers face problems on account of these inadequacies. MTP training centres necessarily are Medical teaching hospitals and thus have regular students. In such situations, regular students get priority over MTP trainees. It has been a consistent experience of the trainees that they don't get sufficient cases of MTP to operate upon by themselves under the supervision of the trainer.

Content of MTP training : The role of counselling in preventing subsequent abortion has been emphasised. Counselling women seeking and/or undergoing MTP was felt important to be incorporated in MTP training by most of the participants. It is important to note that the need of inclusion of counselling skills in the training modules to improve the quality of care in general and abortion in specific are acknowledged by the entire group.

Recommendations :

- The possibility of allowing some private medical set ups for MTP training needs to be explored to attend the problem of inadequate training centres.
- The mechanism to achieve this needs to be evolved with the help of bureaucrats, those concerned in the medical teaching hospitals and the representatives of the private health care sector.[1]
- The MTP training modules need to be reviewed with specific attention to the need of adding the component of counselling skills.

[1] This, however, requires amendments in the MTP Act as the concerned specifications are part of the central Act and do not constitute the state level Rules and Regulations.

2. Lacunae in implementation of the MTP Act and associated problems :

All the three constituencies, namely, the bureaucrats, the doctors or providers and the women who seek abortion care facilities face problems that arise on account of lacunae in the implementation of the Act.

2.1 Problems faced by providers with the inspecting authorities : The problems regarding inspecting authorities are multifaceted. These include their personal biases and irrational and problematic interpretations of the prerequisites mentioned in 'Rules and Regulations' which find mention earlier in this report. In addition, malpractices also occur. Experiences of the participants are more than telling. One of the participants, an MTP provider, mentioned the discrimination that he himself experienced while getting his centre registered. His centre was denied MTP registration status for the reason that there was no blood bank in the vicinity of 5 kms around the centre as stipulated in the Rules and Regulation document of the DHS, Mumbai. However, to his surprise the Primary Health Centre (PHC) there was allowed to conduct MTPs. The concerned PHC was also without an anaesthetist. In addition to this PHC, other two medical centres could also acquire the MTP registration status. He attributed this to the corruption in the bureaucracy. He further added that the inspector insisted on the need to have iron spring cots which finds no mention in the Act. This therefore, has been perceived as the harassment of the providers by the concerned authority. Such an attitude of inspecting authorities, according to many of the participants, often demotivates the latter from pursuing the matter of registration.

Besides, lack of sufficient staff at the concerned government departments to undertake the inspections of medical centres of the applicants worsens the situation further.

Recommendations :

- The concerned government department/s need to improve the quality of supervision and monitoring for better implementation of the Act.
- The staff requirement needs to be reviewed by the concerned government departments and needs to be attended to.

2.2 Husband's signature or consent as a prerequisite - The gap between the legal requirements and providers' perception : The MTP Act doesn't demand husband's signature for a woman to undergo an abortion. Indeed, it is considered a revolutionary feature of the MTP Act and is taken note of worldwide. Providers defended their stand on their demand for husband's signature at the time of abortion on the grounds that in its absence the woman's family and/or husband tend to create problems for providers. One of the participants articulated the issue in the framework of the Laws of Torts. In this regard it was explained that any operation on the reproductive system requires consent of the spouse. According to him in case of complications, if any, during such surgeries the judge/judiciary asks whether husband's signature was sought even in divorce cases.

Doctors from among the participants also pointed out that signature of a witness who generally will be responsible for the person is very much necessary for any invasive procedure, that is, any surgical operation. In this light, seeking signature even at the time of MTP is no different from these situations, according to them. He added that the signature of the witness irrespective of what relationship the person has with the woman is insisted upon in city areas, but in rural areas witness needs to be husband for the reasons mentioned above. Such an attitude of providers reflects more than one thing. First, when it comes to protecting their own interests the legal frameworks are superseded not only conveniently but authoritatively. Secondly, implications of this attitude for women, especially for those whose pregnancies do not fit into the conventional framework, are hardly taken note of by the providers.

However this argument is countered by the organisers. The organisers shared with the participants that tort law can't supersede the legislation. Legislated laws take precedence over the torts laws. There exists no precedence of a judgment against a doctor for performing abortion without husband's signature. Actually speaking the MTP Act while providing protection for the providers does not recognise abortion as woman's right. This has been one of the major criticisms of the MTP Act by the organisers.

Recommendation :

- The MTP service providers should not demand the consent or signature of husband or any family member as a prerequisite for a woman to undergo an abortion.

3. Other issues:

3.1 Significance of medical legislations : The organisers and other participants pointed out that providers' fear about the MTP Act as an obstacle in their practice was misplaced and that providers need to change such views about medical legislation since the Act is a barricade against those who are going to misuse their skills, knowledge and expertise. Looking at the Act as an enemy will not help and is not the right spirit. Medical profession should be a service to human beings. If it is not a service and a consumer activity then the Consumer Protection Act (CPA) comes in the picture. Medical profession has to face CPA because of its commodification in recent past.

However, a strong opinion prevailed about the significance of the legislative measures. It was emphasised that monitoring is necessary for any legislative measures to be effective in reality and to be meaningful to those who are its potential beneficiaries, women in the context of the MTP Act.

Recommendation :

- Providers of health care services in general and of abortion care in specific should not turn away from their responsibilities under misplaced fears about concerned legislation.

3.2 Cost of MTP services : The issue of cost is of specific interest to women, the potential users of these services. The cost of MTP services varies to a great extent. The determinants of the cost as revealed in our studies are both medical and non-medical. The former include factors such as length of gestation, risk involved, diagnostics conducted, experience, reputation of the doctor, etc. The latter is a rather broader category and includes a range of factors such as, the nature of the health care centre and other non-medical facilities at the centre on the one hand and marital status of the woman seeking abortion on the other. Cost of medical care has always been a sensitive issue for medical professionals. While health researchers, health activists and

health advocates have always been raising the issue of standardisation of the cost of medical care, historical evidence indicates that hardly any consensus has ever been reached between medical professionals and health advocates. Against this backdrop it is not surprising that the discussion on standardisation of the cost of MTP services did not reach any consensus. However, the discussion was characterised by the clear distinction in the views of the providers against standardisation and those of others in its favour.

CEHAT representatives acknowledged the long way that we have to go before any such standardisation of the cost of health care in general and MTP services in particular takes place. But CEHAT strongly feels the need to put in collective efforts to achieve that. It was suggested by CEHAT that we may have to look into the Parliamentary Subcommittee Report for Public Announcement of Costs to begin the process.

Recommendation :

- Representatives of the various concerned constituencies should have dialogue on the process of regularising the price of health care services

3.3 Commitment of the public health care system to provide MTP services :
The empirical data in the presentation on access to safe and legal abortion highlighted the failures of public health care system to provide the needs of MTP services, especially of rural women. This is a multifaceted problem. There prevail some fundamental systemic problems in this regard about overall functioning of the public health care facilities and are not restricted to the MTP services alone. Providing MTP services at all the PHCs will be possible only if the minimum infrastructure and personnel requirements both medical and paramedical, are delineated and met with. As per the MTP Act, PHCs are allowed to provide MTP services. However, the poor status of PHCs does not allow them to do so. Poor status and functioning of PHCs have direct implications for people's access to health care in rural areas.

Recommendations :

- All the public health care centres should improve quality of health care services and enhance the IEC component so as to enhance people's access to information which will help them to avoid unwanted pregnancies.
- All the public health care centres from PHC and upwards should provide MTP facilities.

3.4 Sex education : An issue outside the purview of the MTP Act having bearing on women's access to abortion care : The roots of the problem lie seemingly in factors remote from the MTP Act. One such area is need for sex education in our society. We should have some kind of sex education. In a country where talking about sex is taboo, we have to go step by step. Sex education should start from primary to 10th std level, that should be done all over the state/nation. Psychological barriers about sex education should be eliminated. It should be clear that sex education should not restrict itself to the conservative definitions of sexual life and its exclusive permissibility within marriage.

Men's role and the need for men to take responsibility in having safe sex should be emphasised through sex education along with many other facets. People rarely know that it is the man who is fertile all the time whereas the woman is fertile only for 24 days of the year. In every sense it is necessary that men are brought in the picture. Their passivity in taking responsibility is one of the causes of concern and needs to be attended to at various levels. There was no difference of opinion about the key role of education in this regard. Nevertheless it is also recognised that this can't happen overnight and is a long term goal to be achieved. In the meanwhile we should concentrate more on a practicable MTP Act which is woman centred, woman friendly and woman sensitive.

One of the participants while sharing her field level experiences highlighted the fact that in rural areas girls get married at an early age. Young couples are interested in contraception but have neither enough knowledge nor access to such counselling services. In this light education in general and sex education in particular has its own

place in the prevention of situations requiring abortions. She felt that Community Health Workers (CHWs) have a role to play in raising awareness amongst people in this regard.

Recommendation :

- Health and sex education need to be promoted in general for healthy growth of the society and as a preventive measure as regards abortion needs. Such modules need to be formulated carefully and with an all inclusive and a broader perspective so that all the members of society have an opportunity to gain from it.

(B) Session II
Menstrual Regulation as a method of abortion : A Socio-medical and legal evaluation to explore its promotion in India

Highlights of the presentations

The session was intended to generate a discussion on the applicability of MR in the Indian context so as to widen women's choices vis-à-vis safe reproductive health care. The CEHAT team put forward its views through a discussion paper prepared for this consultation. The paper deals with both the methods of MR, surgical and medical. This exercise of socio-medical, legal and feasibility evaluation of MR puts forward a strong case for its promotion to bring down abortion related morbidity and mortality; to enhance the opportunities for potential users to avail of contraceptive services; to reduce the psychological burden of guilt borne by women for undergoing an abortion, amongst others. Evaluation of the legal status of MR suggests that promotion of MR could be considered to enhance women's access to abortion services. Constraints in promoting MR in India and strategies to overcome them were also presented. Both, the advantages and limitations of bringing it under the purview of the MTP Act were also dealt with.

The presentation made by one of the doctor participants, Dr A. N. Shrotri highlighted its medical aspect and advantages of the method. As a practicing gynaecologist at the teaching medical hospital, she emphasised the range of complications that occur on account of MR. She also presented a study conducted in Sassoon Hospital about the efficacy of RU486. It was found that about 91 per cent of women completely aborted within 48 hours from its intake. Women within 6 weeks of gestation showed success rate of 95% while those with 6-8 weeks showed a success rate of 87 per cent.

Discussion

The technical and medical feasibility of MR was generally not challenged. One of the practitioners while sharing his rural experiences said that MR is an effective method and requires no anaesthesia. However, he supported the presenters' view that the providers should be thoroughly trained to conduct this procedure.

Various other issues that came up during the discussion were cost of MR, advantages of MR to the rural women, safety of MR, screening of women for MR, legal status of MR and paramedics getting into MR practice.

The CEHAT team during the presentation emphasised the advantages of MR over other methods for women. One among others was the reduced cost of MR services since it is an office procedure requiring comparatively less infrastructural facilities and avoids hospitalisation. As a result it is expected that the woman pays less for MR services than the conventional MTP. However, the doctors neither seemed to be very convinced about this idea nor were they encouraged to discuss its details.

There was no consensus about the requirement of anaesthesia during MR. The providers held the view that individual woman's tolerance is the determining factor as regards the need of anaesthesia. Medical professionals felt that women having low levels of haemoglobin should not be taken for MR. This is also very important to be considered in the Indian situation.

The issue that was discussed at length and that could enthrall representatives of every constituency the most, was the legal status of MR. Two strong opposite views prevailed among the participants. There was a group of participants, mostly providers, who were in favour of bringing MR under the purview of the MTP Act. This will enable them to go for pregnancy tests so as to avoid unnecessary MR procedures was supported by this group. Leaving MR outside the purview runs the risk of promoting abortion practice by the unqualifieds. The others were in favour of keeping MR outside the purview of the MTP Act. This would allow for widening women's access to abortion care. The rational behind this was that rural women and also women from socially-culturally conservative communities will be benefitted by doing so. While medical professionals approved MR as an option where no other MTP facilities are available, others felt that it could be treated as an alternative to enhance women's access to abortion care and to reap the other advantages that come along with it, viz. : less painful, less trauma, less price, less time, physically more accessible.

A majority of the participants irrespective of their constituencies expressed fear that RU486, like all other drugs may be sold on consumer demand by the pharmacist even

in absence of a proper prescription. Such over-the-counter (OTC) use could be disastrous for women. Hence it should be strictly available only for hospitals.

Reservations and concerns expressed: A number of concerns that were expressed by both the presenters vis-á-vis promotion of the MR either by surgical or medical method. A few are as follows

- MR needs to be conducted within the six weeks of last menstrual period. As a consequence women need to report as early as possible. However, empirical studies and provider experience indicates that there is lack of early reporting and quick decision making about abortion on account of multiple factors which may not be easily controlled.
- This requires strengthening IEC component so that women can avail the facility.
- Counselling should become part and parcel of the provision of the MR service because the woman should be well informed and aware of the symptoms and signs of the probable complications.
- RU486 should not be made available over-the-counter since it requires strict medical vigilance.
- Promotion of any of these methods requires more discussion among the medical professional, paramedics, health activists and those who have been experimenting self-help training in women's health care.

(C) Session III
Paramedics in MR practice

Highlights of the presentation

There were two presentation from among the participants along with the organisers on this theme. The organisers drew attention to the fact that paramedics getting into MR practice has its own potentials and will be advantageous to women, to the providers and to the government. However, a number of reservations about its feasibility that were mentioned by the organiser were elaborated upon by one of the two presenters from among the participants.

He elicited the problem areas in its operationalisation. The fact that the paramedics largely belong to public health care delivery system one requires to take into account its current status and its trend for last several years as regards its quality which includes infrastructure, training, personnel, organisational structure, work culture, counselling and above all the attitude of the staff towards each other and towards the population to whom they are expected to serve. For considering the option of paramedics in MR practice certain basic infrastructural facilities and lacunae in the prevailing system need to be addressed to. In Bangladesh after the training half of doctors and one third of Auxiliary Nurse Midwives (ANMs) stopped conducting MR for lack of infrastructure. Therefore, first target should be PHC. 100 % PHCs should conduct MTPs. Then demand for sub-centre and training of ANM can be made. PHC as a referral and back-up is necessary here, too. While the organiser during presentation expressed an hopeful side of the option by drawing extensively from the positive experiences of Bangladesh the other presenter threw light on some of the critical aspects of the issue. He added that there was tremendous amount of funding and government support in Bangladesh to promote MR. It has been pushed as a method of population control by funding agencies. We have to keep this in mind while discussing the issue of paramedics getting into MR practice as we have faced enough problems arising from coercive population policy for last about five decades.

The other presenter from the participants shared her experiences of self-help training in health care for rural women. Holistic approach to health & health care training

through perspective building were said to be the salient features of these training program. The presenter emphasised that the establishment needs to learn to regard and trust people, their potentials and their capabilities. The experiences of self-help training, as the presenter perceived, are encouraging. Women have been able to run the health resource centres on their own. Based on her experiences with the grassroots women she put forth the view in support of training paramedics and women health workers for MR so as to widen women's access to abortion care. However, the necessary referrals and back-up services and appropriate training need to be central to such efforts was stressed upon.

Discussion

The idea of paramedics getting into MR practice was received with much awe, a little discomfort and with some skepticism, especially by the medical professionals. By and large it was accepted that the paramedics could be trained in conducting MR. However, the magnitude of the constraints arising from the poor status of the existing health care system were felt to be too large/colossal to be ignored.

Danger of misuse and commercialisation of MR at the hands of paramedics was feared by some whereas some others felt that involving ANMs in MR will widen the scope of their services and will increase the effectivity of the ANM and will enhance their image among the people with whom they work. In a way this implies a more positive attitude towards ANM also by those in the hierarchical bureaucratic health care system. However a concern was expressed that the workload of ANMs will further increase without any incentives which will further lower their status in the given bureaucratic health care system. The representative of nurses insisted upon the need for legal protection to paramedics if they are involved in MR practice.

The medical professionals felt the need to work out the cost-benefit ratio as regards this alternative. The cost is in terms of training the paramedics and building the required infrastructure, viz. trainers, training material, equipment and the allied requirements. The benefits will have to be estimated in terms of women who will be benefitted from this. However, the point of view of the researchers, health activists and self-help trainers drew attention to the fact that in conventional term and within the

given framework of bureaucracy cost-benefit ratio may not turn out to be favourable one. But, according to them, the non-tangible and non-measurable gains will immensely outnumber the costs incurred.

The various concerned constituencies expressed different reservations about carrying forward this idea. Medical professionals were concerned about the economics of the option, the representatives of the paramedics were worried about their workload and doubtful about the legal protection that they would like to receive from the state, whereas the health activists and researchers were more hopeful but certainly not without sufficient circumspection.

Reservations & concerns expressed :

- Technically speaking this practice has been established by pioneering experiments. But the need was felt to address the issues of lack of adequate and quality health care infrastructure. The systemic problems would be the major obstructions in considering this option.
- It also needs to be deliberated upon in the wider circles so as to yield better insights.

No recommendations could be formulated since it was felt that the logistics of paramedic-based MR services needs to be worked out. Moreover, no clear consensus emerged about even the basic proposal by paramedic-based MR services.

(III) Outcome

The three areas identified for further pursuance were (a) the content and nature of the MTP Act, (b) the problems at the implementation level and rather impractical prerequisites to acquire MTP registration status that are stipulated in the 'Rules and Regulation' drafted by the State, (c) feasibility of MR as an abortion method, role of paramedics in MR practice. To translate into practice, the discussion that was generated during this consultation, it was necessary to develop some mechanism. Thus, two sub-committees were formed through voluntary initiatives of the participants. They are as follows :

(A) Sub-committee to look into the issue of registration

The committee was expected to look into the existing registration procedure and locate the bottlenecks in the process.

Ms Madhuri Talwalkar, Dr A N Shrotri, Dr Veena Mulgaonkar, Dr Ramesh Junnarkar, Dr Sanjay Gupte, Dr Sunita Bandewar, Ms Mani Mistry and Ms Hema Pisal formed the sub-committee.

The sub-committee met on July 4, '98. Researchers elicited the problems that the medical professionals are facing from the empirical data which was supported by the medical professionals. Lack of information about the details of the registration procedure to the extent that doctors find difficult even to obtain the registration forms. The problem gets severe in rural and semi-urban areas. The registration forms were found to be lacking uniformity. At some places they read ambiguous. Based on this focussed discussion and drawing from consultation held on June 7 the letter has been drafted addressing to the DHS, Mumbai. And it will be followed up in the coming time.

(A) Sub-committee to discuss the feasibility of promoting MR was constituted

Dr Kranti Raymane, Dr Pushpa Tambay, Dr Chandrakant Deshmukh, Dr Sunita Bandewar, Ms Madhuri Sumantare the members of this sub-committee. The sub-committee was to meet on June 20. However, only two members were present for the meeting. Dr Kranti Raymane shared his experiences in the field. The need to address the issue of improving the basic infrastructural facilities at the public health care centres in rural areas and building a concrete and solid IEC component were emphasised.

Annexure - 1(a)

Access to Abortion Services : Taking a Stock of Impediments

by Sunita V Bandewar

Abstract

In India, 25 years after its legalisation through Medical Termination of Pregnancy (MTP) Act, access to abortion still demands attention. The present paper documents socio-cultural and political inaccessibility to abortion services in addition to physical ones. The data presented are drawn partially from the qualitative exploratory study conducted in rural Maharashtra intended to understand the issue from women's perspective and the quantitative study intended to document prevailing quality of abortion care. It is supplemented by secondary data and our experiences.

Data drawn from secondary sources together with preliminary findings of the quantitative survey being conducted presently delineate a poor profile of abortion services. It highlights multiple aspects of access to abortion, such as: number of abortion service centres; their rural and urban distribution, inadequate abortion training facilities, meagre allocation of public funds, poorly maintained government records regarding registered abortion service centres, prevalence of large number of non-registered centres, poor physical standards, lack of woman centred & woman friendly counselling and related back-up services, high abortion costs, distantly placed abortion service centres especially in rural areas, the pressure for husband's signature and post-operative contraceptions/ sterilisation put forth a case of poor implementation of the Act seriously impeding women's access to abortion services. This is in conjunction with the fact that the MTP Act is not without lacunae, such as scope for its varied interpretation by individual abortion providers. On the other hand, the data drawn from the qualitative study indicate that the socio-cultural factors which include women's status in the family and in the community per se, their lack of power to make decisions, have access to information & material and their perceptions about abortion impinges on their access to abortion. It is found that mere legislation doesn't ensure access to abortion in the absence of political will for its meaningful implementation.

Physical access is possible only if society's attitude towards abortion and above all towards women is changed. In addition to discourses on women's rights there is a need to form a lobby to push abortion agenda pragmatically. In this light, revising the MTP Act is an immediate requirement while keeping honest intentions of all those involved in its implementation activated. Moreover, the Information-Education-Communication (IEC) component needs to be strengthened making lawful access more meaningful.

(The paper has been accepted by Economic and Political Weekly for publication.)

Annexure - 1(b)

Menstrual Regulation (MR) as an Abortion Method : A Socio-medical and Legal Evaluation to Explore its Promotion in India

(Discussion paper No 1)

by Sunita V Bandewar

Abstract

The present paper discusses the applicability of menstrual regulation (MR) as an abortion method in the Indian context, necessarily to widen women's reproductive choices. This is done by taking into account its socio-medical advantages, disadvantages and highlighting the experiences of gynaecologists, women's groups, paramedics in countries which are comparable to India with regard to socio-cultural characteristics and health care delivery systems. It discusses the current legal status of MR against that of abortion highlighting the pros and cons of maintaining MR outside the purview of the abortion law. Effort has also been made to evaluate its feasibility in terms of resources and acceptability to providers and users in India.

Evaluation is based on a review of literature on various aspects of MR of the last 25 years. The primary data are drawn from the study on abortion conducted by CEHAT.

This exercise of socio-medical, legal and feasibility evaluation of MR builds a strong case for its promotion to bring down abortion related morbidity and mortality, to enhance the opportunities for potential users to avail of contraceptive services, to reduce the psychological burden of guilt borne by the women for undergoing an abortion, to reduce the intensity of emotional trauma that they experience for having had an abortion. Evaluation of the legal status of MR suggests that it is advisable to keep it outside the purview of the MTP Act, especially to enhance women's access to abortion services and to save them from paper work and inconveniences that they face while meeting the legal requirements under the MTP Act.

Finally, the paper also discusses the constraints in promoting MR in India and strategies to overcome them. The major ones are providers' lethargy, unacceptance of new medical techniques and procedures, lack of systemic arrangements to upgrade knowledge and skills of medical professionals on a continuous basis on the one hand and women's low status in the society affecting their decision making, level of literacy and financial independence on the other. The government too has not recognised MR as one of the effective fertility control methods and a better alternative to abortion in the first trimester. Against this backdrop, the paper emphasises the critical role of the Information-Education-Communication (IEC) component and the need to incorporate it officially in the MR promotion policy.

Annexure - 1(c)

Non-allopaths in Abortion Practice : A Feasibility Evaluation

(Discussion paper No 2)

by Sunita V Bandewar

Abstract

Women's access to abortion care is obstructed despite the legal MTP provisions of the last 25 years for various reasons. Inadequate MTP care centres is one among them. There could be many ways to deal with this particular problem. One such is to explore the possibilities of formalising abortion care facilities that are being provided by non-allopaths[1] on the one hand and imparting MTP care training in the basic medical courses of non-allopaths, that is, ayurveda and homeopathy so as to accommodate them in MTP practice.

This primarily requires an in-depth analysis of their course content on the one hand and critical documentation of experiences of abortion service providers on the other. This paper attempts to do this in a limited sense. Both these exercises will provide guidelines for either accommodating such needs of knowledge and skills in the respective courses and/or formulating the MTP training courses for non-allopaths.

The paper presents a comparative content analysis of the bachelor level courses of allopaths, ayurvedics and homeopaths. Further, it presents some of the related data from our interactions with the abortion providers during our field work, highlighting practical experiences of providers.

'Expansion of abortion care services without compromising its quality' is central to our analysis. This analysis suggests the potential expansion of abortion care services by accommodating ayurvedic practitioners as MTP service providers through legal recognition to them in the MTP Act.

The paper is intended mainly to invoke discussion among the members of the concerned constituencies and especially between the allopaths and non-allopaths. Sharing of experiences and dialogue between these two constituencies is necessary to arrive at practical and reasonable recommendations to be made on this issue.

[1] We have restricted the term non-allopaths to include ayurvedic and homeopathic practitioners only.

Annexure - 1(d)

Paramedics in MR Practice : A Feasibility Evaluation

(Discussion paper No 3)

by Sunita V Bandewar

Abstract

This paper explores the feasibility of paramedic MR service providers in India. An effort has been made to compile the experiences of paramedic MR service providers from developed as well as developing countries. The case of Bangladesh has been considered in particular because of its similarity to India with regard to socio-cultural systems, bureaucracy, concerns for population rise, health care systems, women's health status & their status in general. Based on these experiences, a feasibility exercise has been suggested for India. The cost-effectiveness in medical and social terms is important while considering this choice. To discuss MR as a method of abortion in early phases of pregnancy clearly offers women, especially rural women, more choices for fertility control/reproductive health care. The short as well as long term benefits outweigh the perceived risks involved through non-coercive and woman-oriented means.

However, benefits of having paramedic MR service providers will be realised only if a workable 'evaluation and monitoring system' is developed and implemented. Maintaining the quality of care becomes a prime responsibility of all those involved. Besides technical, financial and human power related factors, motivation & intention for conducting MR and the commitment to self-help approach will play a major role in training and delivery of MR.

(All the three discussion papers prepared for the consultation have been accepted for publication by Radical Journal of Health for the issue Dec 1998. This will be a special volume containing papers on the MR issue.)

Annexure - 2

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Annexure - 3

PROGRAMME

for

The State Level Consultation Meeting on issues related to 'Safe and Legal Abortion'

on Sunday, June 7, 1998, Pune.

Session	Timings	Presenters
Tea & Registration	9.30 -10.00 am	—
Welcome & Introduction	10.00 - 10.30 am	Dr Anant Phadke, Trustee, CEHAT
About CEHAT		Dr Amar Jesani, Co-ordinator, CEHAT
Session I		
Access to abortion :		
Overview of access to abortion care in India	10.30 - 10.50 am	Dr Sunita Bandewar & Mugdha Lele, researchers, REAP
Social & legal barriers to access : MTP Act, problems in registration of MTP centres, demand for husband's signature, training inadequacy		
Quality of health care : Users perspectives	10.50 - 11.00 am	Dr Deepti Chirmulay
Discussion	11.00 - 11.30 am	Chaired by Dr Amar Jesani
Lunch break	1.00 - 2.00 pm	—
Session II		
MR as an method of abortion :		
A Socio-medical and legal evaluation to explore its promotion in India		
Menstrual Regulation (MR) as an abortion method	2.00 - 2.15 pm	Ms Hemlata Pisal, researcher, REAP
Views of medical practitioner on MR	2.15 - 2.30 pm	Dr A N Shrotri, Faculty member, B J Medical College, Pune
Discussion	2.30 -3.15 pm	Chaired by Dr Arvind Deshpande, Consultant, REAP
Tea break	3.15 - 3.30 pm	—
Session III		
Paramedics in MR practice		
Role of non-allopaths and paramedics in MTP	3.30 - 3.45 pm	Ms Madhuri Sumant
Experiences of self-help groups	3.45 - 4.00 pm	Sabla, Health Activist & Ms Chandra Karhadkar, MASUM
Views of medical doctor turned an health activist	4.00 - 4.15 pm	Dr Abhay Shukla, Researcher & Health Activist
Discussion	4.15 - 4.45 pm	Chaired by Mr Sunil Nandraj, Sr Researcher, CEHAT
Changes needed/strategy for advocacy	4.45 - 5.45 pm	Chaired by Ms Mani Mistry
Thanks giving and Closing	5.45 - 6.00 pm	Mugdha Lele, CEHAT

Annexure - 4

Our Publications on abortion

Papers, essays and press articles :

Stree Arogya wa Garbhapat, Pisal Hemlata in *Bayaja, Diwali Visheshank,* 1998, pp. 78-82. (Press article in Marathi).

Garbhapat Kayada ani Vastav, Sumant Madhuri in *Loksatta,* April 11, 1998, pp 4. (Press article in Marathi)

Garbhapatavishai Jenva Bayaka Manatala Boltat, Bandewar Sunita in *Saptahik Sakal*, April 4, 1998, pp. 8-13, 61-62. (Press article in Marathi).

Abortion : Cause for concern in India, even 25 years after its legislation, Bandewar Sunita; prepared for 6th National Conference of Women's Movements; Ranchi, Bihar, Dec. 28-30, 1997.

Women's role in decision making in abortion: Profiles from rural Maharashtra, Gupte Manisha, Bandewar Sunita, Pisal Hemlata. Paper tabled at XIV International Conference of the Social Science and Medicine at Peebles, Scotland, September 2-6, 1996, pp. 22

Abortion needs of women : A case study of rural Maharashtra, Gupte Manisha, Bandewar Sunita, Pisal Hemlata; in *Reproductive Health Matters,* Special issue titled Abortion : The Unfinished Business; Number 9; May 1997, pp. 77-86.

Women's perspectives on the quality of health care and reproductive health care: Evidence from rural Maharashtra, Gupte Manisha, Bandewar Sunita, Pisal Hemlata (Scheduled for publication in a book to be brought out by the Ford Foundation); Pune: CEHAT, December 1995, pp. 28.

Abortion : Who is responsible for our rights?, Jesani Amar, Iyer Aditi in Karkal Malini (Ed.) Our lives, our health, New Delhi: Coordination Unit, World Conference on Women, Beijing, 1995, August 1995, pp. 114-130.

Women and abortion, Jesani Amar, Iyer Aditi; in *Economic and Political Weekly*, November 27, 1993, pp. 2591-94 (A background paper for the MFC meet on "Social construction of reproduction" at Wardha, January 13-15, 1995).

Visual aids and training material :

Vyatha Streechi, Katha Garbhapatachi, Gupte Manisha, Pisal Hemlata, Bandewar Sunita (Slide Show in Marathi), 1995.

Amchya Sharirawar Aamcha Hakka; Gupte Manisha, Pisal Hemlata, Bandewar Sunita, (booklet in Marathi), 1996.

Note : Reprints, visual aids and training material are available at Mumbai and Pune office of CEHAT.

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